Instructions for: AFFIDAVIT OF WITHDRAWING CONSENT TO IMMUNIZATION

1.) Use either the Affidavit for an Adult with children, or the Affidavit for an Adult with no children.

2.) ONLY fill and sign before a justice of the peace, commisioner for oaths or notary public. Ensure Exhibits are included in the afffidavit. (Note: every Saskatchewan MLA is a notary public)

3.) Make a second copy of affidavit with exhibits for your own records.

4.) Send the original copy by personally delivering or sending with Registered Mail to your local Public Health Inspector, who can be contacted below for their address.

5.) If you personally deliver it make a note of the person you serve, date, and time. If you send with Registered Mail track the letter and print the proof of signature/delivery confirmation for your own records.

La Ronge	306-425-8512	healthinspectors@pophealthnorthsask.ca
Melfort	306-752-6310	publichealth@kthr.sk.ca
Moose Jaw	306-691-1500	phi@fhhr.ca
North Battleford	1-888-298-0202	PublicHealthInspection@pnrha.ca
Prince Albert	306-765-6600	public.health.inspection@paphr.sk.ca
Regina	306-766-7755	EnvironmentalHealth@rqhealth.ca
Rosetown	306-882-2672 (Extension 3, then Option 3)	Public.Health@hrha.sk.ca
Saskatoon	306-655-4605	PHIOC@saskatoonhealthregion.ca
Swift Current	306-778-5280	phis@cypressrha.ca
Weyburn	306-842-8618	PubHealthInspection@schr.sk.ca
Yorkton	306-786-0600	PublicHealthInquiries@shr.sk.ca

Download more copies for your friends and family with the Telegram app at:

Saskatchewan Vaccine Exemption
https://t.me/exemptfromjab

CANADA

PROVINCE OF SASKATCHEWAN

TO WIT

AFFIDAVIT FOR WITHDRAWING CONSENT TO IMMUNIZATION

I, _____ of the _____ of _____, Province of Saskatchewan, MAKE OATH AND SAY THAT:

1. I am of legal age and of sound mind. I have personal knowledge of the facts stated below.
2. Government of Canada has stated, *"However, It is possible for someone to have a serious adverse reaction to a vaccine"*. Attached to this my affidavit as Exhibit "A" is a true copy of Government of Canada Announces pan-Canadian Vaccine Injury Support Program, 2020-12-10 press release.
3. Government of Canada has a form for the nation wide reporting of an adverse reaction to immunization which details possible adverse reactions in the form of death, vaccine reactions, vaccine allergic events, neurological events, and other events. Attached to this my affidavit as Exhibit "B" is a true copy of Report of Adverse Events Following Immunization (AEFI), form.
4. The names of my children are _____.
5. Immunization with vaccine products would be harmful to my physical and mental health, and my children's physical and mental health.
6. I withdraw my consent to be immunized with vaccine products. On behalf of my children, I withdraw consent for them to be immunized with vaccine products.
7. I am equal in dignity, rights and responsibilities as that of an immunized person, as protected under both the *Saskatchewan Human Rights Code, 2018*, and the *Canadian Human Rights Act.*
8. I am excused from compliance with any regulation, bylaw or order of the *The Public Health Act, 1994* that makes immunization mandatory. Attached to this my affidavit as Exhibit "C" is a true copy of *Section 64(2) of The Public Health Act, 1994*.

SWORN BEFORE ME

at, _____ , Saskatchewan,

this _____day of _____ ,

2_____ .

_____

Commissioner for Oaths
for Saskatchewan

_____

(*Signature of the Deponent*)

CANADA

PROVINCE OF SASKATCHEWAN

TO WIT

AFFIDAVIT FOR WITHDRAWING CONSENT TO IMMUNIZATION

I, _____ of the _____ of _____, Province of Saskatchewan, MAKE OATH AND SAY THAT:

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4. Immunization with vaccine products would be harmful to my physical and mental health.
5. I withdraw my consent to be immunized with vaccine products.
6. I am equal in dignity, rights and responsibilities as that of an immunized person, as protected under both the *Saskatchewan Human Rights Code, 2018*, and the *Canadian Human Rights Act.*
7. I am excused from compliance with any regulation, bylaw or order of the *The Public Health Act, 1994* that makes immunization mandatory. Attached to this my affidavit as Exhibit "C" is a true copy of *Section 64(2) of The Public Health Act, 1994*.

SWORN BEFORE ME

at, _____ , Saskatchewan,

this _____day of _____ ,

2_____ .

_____

Commissioner for Oaths
for Saskatchewan

_____

(*Signature of the Deponent*)

Exhibit "A"

Government of Canada Announces pan-Canadian Vaccine Injury Support Program

From: Public Health Agency of Canada

News release

December 10, 2020 - Ottawa, ON - Public Health Agency of Canada

We as Canadians pride ourselves on our commitment to each other. By getting vaccinated, we protect one another and our way of life. Vaccines are safe, effective and one of the best ways to prevent serious illness like COVID-19.

Vaccines are only approved in Canada after thorough and independent review of the scientific evidence. They are also closely monitored once on the market and can quickly be removed from market if safety concerns are identified. Notwithstanding the rigour of clinical trials and excellence in vaccine delivery, a small number of Canadians may experience an adverse event following immunization, caused by vaccines or their administration.

Like any medication, vaccines can cause side effects and reactions. After being vaccinated, it's common to have mild and harmless side effects — this is the body's natural response, as it's working to build immunity against a disease. However, it is also possible for someone to have a serious adverse reaction to a vaccine. The chances of this are extremely rare — less than one in a million — and we have a duty to help if this occurs.

It is for this reason that the Public Health Agency of Canada (PHAC) is implementing a pan-Canadian no-fault vaccine injury support program for all Health Canada approved vaccines, in collaboration with provinces and territories. Building on the model in place in Québec for over 30 years, the

program will ensure that all Canadians have to have fair access to support in the rare event that they experience an adverse reaction to a vaccine. This program will also bring Canada in line with its G7 counterparts with similar programs, and ensure the country remains competitive in accessing new vaccines as they become available.

Quotes

> "Our publicly funded health care system is a source of pride, and this program will make it even better. Canadians can have confidence in the rigour of the vaccine approvals system, however, in the rare event that a person experiences an adverse reaction, this program will help ensure they get the support they need. I will work with my provincial and territorial counterparts to set this program in place quickly."
>
> *The Honourable Patty Hajdu*
> *Minister of Health*

Quick facts

- Serious adverse reactions to vaccines are extremely rare. They happen less than one time in a million.
- Once a vaccine is in use, Canada has a strong vaccine safety monitoring system that involves healthcare professionals, vaccine manufacturers, the provinces and territories, the Public Health Agency of Canada, and Health Canada, to alert public health authorities of changing trends or unusual adverse events that were not previously reported.
- Over 20 countries around the world have national vaccine injury support programs, including all other G7 countries.

Associated links

- Canada.ca/coronavirus

Contacts

Cole Davidson
Office of the Honourable Patty Hajdu
Minister of Health
613-957-0200

Media Relations
Public Health Agency of Canada
613-957-2983
hc.media.sc@canada.ca

COVID-19 public enquiries:
1-833-784-4397

Search for related information by keyword: Immunization | Public Health Agency of Canada | Canada | Health care system | Diseases and conditions | general public | news releases | Hon. Patricia A. Hajdu

Date modified:
2020-12-10

Exhibit "B"

Public Health Agency of Canada | Agence de la santé publique du Canada

Protected B When Completed

Report Of Adverse Events Following Immunization (AEFI)

Instructions: For more complete instructions and definitions, refer to the *user guide* at:
https://www.canada.ca/en/public-health/services/immunization/reporting-adverse-events-following-immunization/user-guide-completion-submission-aefi-reports.html

Report events which have a temporal association with a vaccine and which cannot be clearly attributed to other causes. A causal relationship does not need to be proven, and submitting a report does not imply causality.

Of particular interest are those AEFIs which:

a. Meet one or more of the seriousness criteria
b. Are unexpected regardless of seriousness.

Refer to the user guide, Background Information for additional clarification.

Note:

- **The numbers below correspond to the numbered sections of the form.**
- **All dates should be captured in the following format: YYYY/MM/DD.**
- **When reporting an AEFI, check one of the boxes on the top right hand corner of the first page of the AEFI form to indicate whether it is an "initial" or "follow up" report. For all follow up reports, please specify the "Unique Episode number".**

1a. The **"Unique episode number"** is assigned by the Province/Territory. Leave it blank unless authorized to assign it.

1b. The **"Region number"** is a number that corresponds to a given health unit. Leave it blank if it doesn't apply to your locale.

2. The "IMPACT LIN" is assigned by Impact nurse monitors (LIN: Local Inventory Number).

3. The information captured in this section is confidential and is intended for use **only** by the regional and/or provincial/territorial health officials.

4a. Indicate the Province/Territory where the vaccine was administered, abbreviations may be used.

4c. Provide all information as requested in the table. For the "Dose #", provide the number in series (1, 2, 3, 4, 5 or booster) if known. For the Influenza vaccine, unless a patient receives two doses in one season, the "Dose #" should be recorded as "1".

7a. Indicate the highest impact of the AEFI on the patient's daily activities as assessed by the patient or the parent/caregiver.

7c. Provide details of any investigations or treatments in section 10. If the patient was already in hospital when immunized and the immunization resulted in a longer hospital stay, indicate "Resulted in prolongation of existing hospitalization" and provide the number of days by which the patient's hospital stay was prolonged. For all hospitalizations, indicate the date of admission and discharge.

8. MOH/MHO: Medical Officer of Health, MD: Medical Doctor, RN: Registered Nurse.

9. Choose, from section 9 (AEFI details), the description that best fits the AEFI being reported. Make sure to record the time of onset and duration of signs/symptoms using the most appropriate time unit: Days, Hours or Minutes. Provide additional details of any investigation, therapy, and other information as appropriate in section 10.

11. This section is to be completed by the MOH/MHO, MD, RN or their designate who are assigned to provide public health recommendations according to the P/T best practices.

12. Information in this section is not collected by all P/Ts.

Return completed form to your local public health unit address at:

Alberta (AB)	Northwest Territories (NT)	Quebec (QC)
British Columbia (BC)	Nova Scotia (NS)	Saskatchewan (SK)
Manitoba (MB)	Nunavut (NU)	Yukon (YT)
New Brunswick (NB)	Ontario (ON)	Canadian Forces Health Services (CFHS)
Newfoundland and Labrador (NL)	Prince Edward Island (PE)	Public Health Agency of Canada (PHAC)

PHAC 03/2019

Canada

2 | Report Of Adverse Events Following Immunization (AEFI)

◯ Initial report
◯ Follow up report (Unique episode #)

1a. Unique episode #: _____ 1b. Region #: _____ 2. IMPACT LIN: _____

3. Patient Identification

First name: _____ Last name: _____ Health number: _____

Address of usual residence: _____

Province/Territory: _____ Postal code: _____ Phone: _____ ext #: _____

Information Source: First name: _____ Last name: _____ Relation to patient: _____

Contact info, if different: _____

4. Information at Time of Immunization and AEFI Onset

4a. At time of immunization: Province/Territory of immunization: _____

Date vaccine administered (YYYY/MM/DD): _____ (hr: ◯ am/ ◯ pm) Date of birth (YYYY/MM/DD): _____ Age: _____

Sex: ◯ Male ◯ Female ◯ Other _____ ☐ Pregnant at time of immunization: ☐ Gestation ☐ weeks ☐ days

4b. Medical history (up to the time of AEFI onset) *(Check all that apply and provide details in section 10)*

☐ Concomitant medication(s) ☐ Known medical conditions/allergies ☐ Acute illness/injury

4c. Immunizing agent	Trade name	Manufacturer	Lot number	Dose #	Dosage/unit	Route	Site
					/		
					/		
					/		
					/		
					/		
					/		
					/		

5. Immunization Errors

Did this AEFI follow an incorrect immunization? ◯ No ◯ Unknown ◯ Yes

(If Yes, choose all that apply and provide details in section 10)

☐ Given outside the recommended age limits ☐ Product expired
☐ Wrong vaccine given ☐ Incorrect route
☐ Dose exceeded that recommended for age ☐ Other, specify: _____

6. Previous AEFI

Did an AEFI follow a previous dose of any of the above immunizing agents (Table 4c)?

(Choose one of the following)

◯ No ◯ Yes *(Provide details in section 10)*
◯ Unknown ◯ Not applicable *(no prior doses)*

Note: Discuss with patient or his/her parent/caregiver reason for reporting and confidentiality of information

Unique episode #: ☐ **Region #:** ☐ **IMPACT LIN:** ☐

7. Impact of AEFI, Outcome, and Level of Care Obtained

7a. Highest impact of AEFI: *(Choose one of the following)*

- ◯ Did not interfere with daily activities
- ◯ Interfered with but did not prevent daily activities
- ◯ Prevented daily activities

7b. Outcome at time of report: *(Provide details in section 10 for items with †)*

- ◯ Death† Date (YYYY/MM/DD): ☐
- ◯ Permanent disability/incapacity† ◯ Not yet recovered†
- ◯ Fully recovered ◯ Unknown

7c. Highest level of care obtained: *(Choose one of the following)*

◯ Unknown ◯ None ◯ Telephone advice from a health professional ◯ Non-urgent visit ◯ Emergency visit
◯ Required hospitalization (☐ days) **OR** ◯ Resulted in prolongation of existing hospitalization (by ☐ days)
Date of hospital admission (YYYY/MM/DD): ☐ Date of hospital discharge (YYYY/MM/DD): ☐

7d. Treatment received: ◯ No ◯ Unknown ◯ Yes *(Provide details of all treatments including self-treatment, in section 10)*

8. Reporter Information

Setting : ◯ Physician office ◯ Public health ◯ Hospital ◯ Workplace Clinic ◯ Other, specify: ☐

Name: ☐ Phone: ☐ Ext #: ☐ Fax: ☐

Address: ☐

City: ☐ Prov/Terr: ☐ Postal code: ☐ Date reported (YYYY/MM/DD): ☐

Signature: _____ ◯ MD ◯ RN ◯ Impact ◯ Pharmacist ◯ Other, specify: ☐

9. AEFI Details: Complete all sections as appropriate; for each, check all signs/symptoms that apply. Item(s) with asterisk (*) should be diagnosed by a physician. If not, provide sufficient information to support the selected item(s). Use Section 10 foradditional information including, clinical details and test results.

☐ **9a. Local reaction at or near vaccination site**

Interval: ☐ Min ☐ Hrs ☐ Days from immunization to onset of 1st symptom or sign
Duration: ☐ Min ☐ Hrs ☐ Days from onset of 1st symptom/sign to resolution of all symptoms/signs

☐ Infected abscess ☐ Sterile abscess ☐ Cellulitis ☐ Nodule ☐ Reaction crosses joint ☐ Lymphadenitis
☐ Other, specify: ☐

For any vaccination site reaction indicated above, check all that apply below and provide details in section 10:

☐ Swelling ☐ Pain ☐ Tenderness ☐ Erythema ☐ Warmth ☐ Induration ☐ Rash
☐ Largest diameter of vaccination site reaction: ☐ cm Site(s) of reaction ☐ (e.g. LA, RA)
☐ Palpable fluctuance ☐ Fluid collection shown by imaging technique (e.g. MRI, CT, ultrasound)
☐ Spontaneous/surgical drainage ☐ Microbial results ☐ Lymphangitic streaking ☐ Regional lymphadenopathy

Unique episode #: _____ Region #: _____ IMPACT LIN: _____

☐ **9b. Allergic and Allergic-like events**

Interval: ☐ Min ☐ Hrs ☐ Days from immunization to onset of 1st symptom or sign

Duration: ☐ Min ☐ Hrs ☐ Days from onset of 1st symptom/sign to resolution of all symptoms/signs

Choose one of the following: ○ **Anaphylaxis** ○ **Oculo-Respiratory Syndrome (ORS)** ○ **Other allergic events**

Skin /mucosal

☐ Urticaria ☐ Erythema ☐ Pruritus ☐ Prickle sensation ☐ Flushing ☐ Other Rash

○ **Generalized** ○ **Localized** *(site)* _____

☐ **Angioedema:** ☐ Tongue ☐ Throat ☐ Uvula ☐ Larynx ☐ Lip

☐ Eyelids ☐ Face ☐ Limbs ☐ Other, *specify:* _____

Eye(s): ☐ Red bilateral ☐ Red unilateral ☐ Itchy

Cardio-vascular

☐ Measured hypotension ☐ ↓ central pulse volume ☐ Capillary refill time > 3 sec

☐ Tachycardia ☐ ↓ or loss of consciousness (*Duration*) _____

Respiratory

☐ Sneezing ☐ Rhinorrhea ☐ Hoarse voice ☐ Sensation of throat closure ☐ Stridor

☐ Dry cough ☐ Tachypnea ☐ Wheezing ☐ Indrawing/retractions ☐ Grunting

☐ Cyanosis ☐ Sore throat ☐ Difficulty swallowing ☐ Difficulty breathing ☐ Chest tightness

Gastrointestinal

☐ Diarrhea ☐ Abdominal pain ☐ Nausea ☐ Vomiting

☐ **9c. Neurologic events**

Interval: ☐ Min ☐ Hrs ☐ Days from immunization to onset of 1st symptom or sign

Duration: ☐ Min ☐ Hrs ☐ Days from onset of 1st symptom/sign to resolution of all symptoms/signs

☐ **Meningitis*** ☐ **Encephalopathy/Encephalitis*** ☐ **Guillain-Barre Syndrome (GBS)*** ☐ **Bell's Palsy***

☐ **Other Paralysis*** ☐ **Seizure** ☐ **Anaesthesia** ☐ **Paraesthesia** ☐ **Other neurologic diagnosis*, *specify:*** _____

☐ Depressed/altered level of consciousness ☐ Lethargy ☐ Personality change lasting ≥ 24hrs ☐ Focal or multifocal neurologic sign(s)

☐ Fever (≥ 38.0°C) ☐ CSF abnormality ☐ EEG abnormality ☐ EMG abnormality ☐ Neuroimaging abnormality

☐ Brain/spinal cord histopathologic abnormality ☐ Numbness ☐ Tingling ☐ Burning ☐ Formication ☐ Other, *specify:* _____

Type of Seizure:

○ **Partial Seizure** OR ○ **Generalized Seizure** (*Specify*: ○ Tonic ○ Clonic ○ Tonic-Clonic ○ Atonic ○ Absence ○ Myoclonic)

Seizure details: ☐ Sudden loss of consciousness ○ Yes ○ No ○ Unknown

☐ Witnessed by healthcare professional ○ Yes ○ No ○ Unknown

☐ Previous history of seizures (*Specify*: ○ Febrile ○ Afebrile ○ Unknown type)

☐ **9d. Other events**

Interval: ☐ Min ☐ Hrs ☐ Days from immunization to onset of 1st symptom or sign

Duration: ☐ Min ☐ Hrs ☐ Days from onset of 1st symptom/sign to resolution of all symptoms/signs

☐ **Hypotonic-Hyporesponsive Episode (age < 2 years)** ☐ Limpness ☐ Pallor/cyanosis ☐ ↓ responsiveness/unresponsiveness

☐ **Persistent crying** (*Continuous and unaltered crying for ≥ 3 hours)*

☐ **Intussusception***

☐ **Arthritis** ☐ Joint redness ☐ Joint warm to touch ☐ Joint pain ☐ Joint swelling ☐ Inflammatory changes in synovial fluid

☐ **Parotitis** *(Parotid gland swelling with pain and/or tenderness)*

☐ **Rash *(Non-allergic)*** ○ Generalized ○ Localized (*Site*)

Unique episode #: ☐ **Region #:** ☐ **IMPACT LIN:** ☐

☐ **Thrombocytopenia*** ☐ Clinical evidence of bleeding ☐ Platelet count < $150x10^9$/L ☐ Petechial rash ☐ Other clinical evidence of bleeding

☐ **Severe vomiting** *(Severe enough to interfere with daily routine)*

☐ **Severe diarrhea** *(Severe enough to interfere with daily routine)*

☐ **Fever ≥ 38.0°C** *(NOTE: report **only** if fever occurs in conjunction with another reportable event. For fever in a neurological event, use section 9c)*

☐ **Other serious or unexpected event(s) not listed in the form** *(Describe in section 10)*

10. Supplementary information: *(Please indicate the section number when providing details. Please provide details of any investigation or treatment for the recorded AEFI. If not, provide sufficient information to support the selected item(s)).*

11. Recommendations for future immunization(s) according to the Federal/Provincial/Territorial best practices.

(Provide comments, use section 10 if extra space needed)

☐ No change to immunization schedule	☐ Controlled setting for next immunization	Other, *specify:*
☐ Expert referral, *specify:* ☐	☐ No further immunizations with: ☐ *specify:* ☐	☐
☐ Determine protective antibody level	☐ Active follow up for AEFI recurrence after next vaccine	

Name: ☐ Professional status: ◯ MOH/MHO ◯ MD ◯ RN ◯ Other, *specify:* ☐

Comments:

Phone: ☐ (ext #: ☐) Date (YYYY/MM/DD): ☐ Signature

12. Follow up information for a subsequent dose of same vaccine(s) *(Provide details in section 10)*

☐ Vaccine administered without AEFI ☐ Vaccine administered with recurrence of AEFI ☐ Vaccine administered, other AEFI observed
☐ Vaccine administered without information on AEFI ☐ Vaccine not administered

Exhibit "C"

(ii) for a second or subsequent offence:

(A) to a fine of not more than $250,000; and

(B) to a further fine of not more than $5,000 for each day during which the offence continues.

1994, c.P-37.1, s.61.

Offences by corporations, etc.

62 Where a corporation is guilty of an offence mentioned in section 61, every officer, director, manager or agent of the corporation who directed, authorized or participated in the commission of the offence is also guilty of the offence and is liable on summary conviction to the penalties for the offence that are set out in section 61, whether or not the corporation has been prosecuted.

1994, c.P-37.1, s.62.

Limitation

63 No prosecution with respect to an alleged offence pursuant to this Act or any regulations, bylaws or orders made pursuant to this Act is to be commenced after two years from the day of the commission of the alleged offence.

1994, c.P-37.1, s.63.

PART VII
General

Conscientious objection to immunization

64(1) A person who conscientiously believes that immunization or prophylaxis would be prejudicial to his or her health or to the health of his or her child or ward, or who for conscientious reasons objects to immunization or prophylaxis, may swear or affirm an affidavit to that effect before a justice of the peace, commissioner for oaths or notary public.

(2) A person described in subsection (1) is excused from compliance with any regulation, bylaw or order pursuant to this Act that makes immunization mandatory if the person delivers personally or by registered mail to the local authority for the area in which the person resides a duly attested affidavit described in that subsection.

1994, c.P-37.1, s.64; 2003, c.29, s.70.

Confidentiality

65(1) Subject to subsection (2), no person shall disclose any information that comes to the person's knowledge in the course of carrying out responsibilities pursuant to this Act, the regulations or bylaws made pursuant to this Act concerning a person who:

(a) is infected with or is suspected to be infected with a communicable disease;

(b) is a carrier of or is suspected to be a carrier of a communicable disease;

(c) is a contact of a person mentioned in clause (a) or (b); or

(d) has or has had a non-communicable disease or an injury.